

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL****FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

9 7 - 2 7

2. STATE:

New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

April 1, 1997

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447 Subpart F

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B Pages 1(b), 1(c)(i), 2(a), 2(b),
2(c), 4, 4(a)(iii), 4(a)(iv), 4(a)(iv)(1), 4(a)(v),
7(c), 7(c)(i), 7(c)(ii), 8(a), 8(a)(i), 10, 14

** SEE REMARKS

7. FEDERAL BUDGET IMPACT:

a. FFY 1996-1997 \$ 57.39m

b. FFY 1997-1998 \$ 114.76m

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Attachment 4.19-B Pages 1(b), 2(a), 2(b),
2(c), 4, 4(a)(iii), 4(a)(iv), 4(a)(v), 8(a) 10, 14

** SEE REMARKS

No Previous Pages: 1(c)(i), 4(a)(iv)(1),
7(c), 7(c)(i), 7(c)(ii),
8(a)(i)

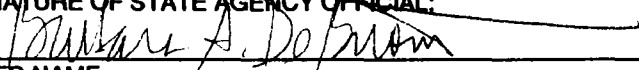
10. SUBJECT OF AMENDMENT:

Non-Institutional Services

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Barbara A. DeBuono, M.D., M.P.H.

14. TITLE:

Commissioner

15. DATE SUBMITTED:

June 30, 1997

16. RETURN TO:

New York State Department of Health
Corning Tower
Empire State Plaza
Albany, New York 12237

New York
1(b)

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(two year trend movement) on a per visit basis, except that commencing April 1, 1995 through March 31, 1999 for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or Statewide ceiling of \$150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of \$67.50 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that for the period October 1, 1995 through March 31, 1999, the capital cost per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of \$95 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that for the period of October 1, 1995 through March 31, 1999, the capital costs per visit components shall be adjusted by the Commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services

Hospital-Based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services.

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1(c)(i)**

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payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law; Including Federally Qualified Health Centers

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995 through March 31, 1999, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The rates include a

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capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, 1995 shall continue in effect ~~[thereafter]~~ through September 30, 1999. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Payment rates for renal dialysis services of \$150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

Designated Preferred Primary Care Provider for Freestanding Diagnostic and Treatment Centers

Freestanding diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resources use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add-on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities.

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1(e)**

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The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995 shall continue in effect ~~[thereafter]~~ through September 30, 1999.

A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits. Notwithstanding any inconsistent provision of this paragraph, adjustments to rates of payment for diagnostic and treatment centers for such supplemental bad debt and charity care allowance shall apply only for services provided on or before December 31, 1996.

For services provided on or after April 1, 1995, by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial

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Hospital Based Outpatient Department

Facilities Certified Under Article 28 of the Public Health Law

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law As Freestanding Diagnostic and Treatment Centers

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect [thereafter] through September 30, 1999.

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**New York
2(c)**

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Hospital Based Outpatient Department

**Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based
Outpatient Departments**

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. for each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

**Freestanding Diagnostic and Treatment
Centers**

**Facilities Certified Under Article 28 of the Public Health Law as Freestanding
Diagnostic and Treatment Centers**

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect [thereafter] through September 30, 1999.

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(6/97)****Laboratory Services**

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended, or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April 1, 1995 through December 31, 1995 and for rate periods beginning on or after January 1, 1996 through March 31, 1999, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996, [and] 1997, 1998, and 1999 rate periods, respectively, the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1 of the year prior to the respective rate period through March 31 of such respective rate period shall be adjusted in the respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15 of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31 of the applicable twelve month period, to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars.

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4(a)(iii)**

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Effective for the period August 1, 1996 through March 31, [1997] 1999, Certified home health agencies (CHHAs) shall be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period [~~August 1, 1996 to March 31, 1997~~] (the 1996 target period is August 1, 1996 through March 31, 1997, the 1997 target period is January 1, 1997 through November 30, 1997, and the 1998 target period shall mean January 1, 1998 through November 30, 1998) or receive a reduction in their Medicaid payments. For this purpose, regions shall consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency shall be located in the same county utilized by the Commissioner of Health for the establishment of rates pursuant to Article 36 of the Public Health Law. Regional group shall mean all those CHHAs located within a region. Medicaid revenue percentage shall mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to Title 11 of Article 5 of the Social Services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare).

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentage for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate shall be calculated. Prior to February 1, 1998 and prior to February 1, 1999, for each regional group, the Commissioner of Health shall calculate the prior year's Medicaid revenue percentages for the period beginning January 1 through November 30 of such prior year. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage shall be calculated.

For each regional group, the 1996 target Medicaid revenue percentage shall be calculated as the result of subtracting the 1996 Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The 1996 Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

- one and one-tenth percentage points for CHHAs located within the downstate region;
- and,
- six-tenths of one percentage point for CHHAs located within the upstate region.

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4(a)(iv)**

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For 1997 and 1998, for each regional group, the target Medicaid revenue percentage for the respective year shall be calculated the result of subtracting the respective year's Medicaid revenue reduction percentage from the base period Medicaid revenue percentage. The Medicaid revenue reduction percentage for 1997 and 1998, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region;
and,

six-tenths of one percentage point for CHHAs located within the upstage region.

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor shall be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the 1996 Medicaid revenue reduction percentage. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor shall be zero. For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount.

two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For 1997 and 1998, for each regional group, if the Medicaid revenue percentage for the respective year is not equal to or less than the target Medicaid revenue percentage for such respective year, the Commissioner of Health shall compare such respective year's Medicaid revenue percentage to such respective year's target Medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's Medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the Medicaid revenue percentage for a particular year is equal to or less than the target Medicaid revenue percentage for that year, the reduction factor for that year shall be zero. For 1997 and 1998 for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

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4(a)(iv)(1)**

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two million three hundred ninety thousand dollars (\$2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars (\$750,000) for CHHAs located within the upstate region;

For each regional group reduction, if the reduction factor for a particular year is zero, there shall be no state share reduction amount for such year.

For each regional group, the 1996 state share reduction amount shall be allocated among CHHAs on the basis of the extent of each CHHAs failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHAs failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount. This amount shall be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped by the State by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

For 1997 and 1998, for each regional group, the state share reduction amount for the respective year shall be allocated among CHHAs on the basis of the extent of each CHHAs failure to achieve the target Medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHAs failure to achieve the target Medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount for the applicable regional group. This amount shall be called the provider specific state share reduction amount for the applicable year.

The provider specific state share reduction amount for 1997 and 1998, respectively, shall be due to the state from each CHHA and the amount due for each respective year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA pursuant to Title 11 of Article 5 of the Social Services Law.

CHHAs shall submit such data and information at such times as the Commissioner of Health may require. The Commissioner of Health may use data available from third party payors.

On or about June 1, 1997, for each regional group, the Commissioner of Health shall calculate for the period of August 1, 1996 through March 31, 1997, a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider

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4(a)(v)

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specific state share reduction amount in accordance with the methodology provided herein for calculating such amounts for the 1996 target period. The provider specific state share reduction amount calculated shall be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 provider specific state share reduction amount, the difference shall be refunded to the CHHA by the state no later than July 15, 1997. CHHAs shall submit data for the period August 1, 1996 through March 31, 1997 to the Commissioner of Health by April 15, 1997.

If a CHHA fails to submit data and information as required, such CHHA shall be presumed to have no decrease in Medicaid revenue percentage between the base period and the applicable target period for purposes of the calculations described herein and the Commissioner of Health shall reduce the current rate paid to such CHHA by state governmental agencies pursuant to Article 36 of the Public Health Law by one percent for the period beginning on the first day of the calendar month following the applicable due date as established by the Commissioner of Health and continuing until the last day of the calendar month in which the required data and information are submitted.

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7(a)

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Section 86-2.9, Adult Day Health Care in Residential Health Care Facilities, is hereby amended to read as follows:

Section 86-2.9 Adult Day Health Care in Residential Health Care Facilities: (a) Except as specifically identified in subdivision (g), rates for residential health care facility services for adult day health care registrants shall be computed on the basis of the allowable costs, as reported by the residential health care facility, and the total number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(b) For adult day health care programs without adequate cost experience, rates will be computed based upon annual budgeted allowable costs, as submitted by the residential health care facility and the total estimated annual number of visits by adult day health care registrants, as defined in Part 425 of this Title, for which services were delivered pursuant to Article 6 of Subchapter A of Chapter V of this Title subject to the maximum daily rate provided for in this section.

(c) Allowable costs shall include, but not be limited to the following:

- (1) applicable salary and non-salary operating costs;
- (2) costs of transportation; and,
- (3) appropriate portion of capital costs, allocated according to instructions accompanying the RHCF-4 report.

(d) the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this title shall be 75 percent of the sponsoring facility's former skilled nursing facility rate in effect on January 1, 1990, with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

(e) notwithstanding subdivision (d) of this section or any other regulations to the contrary, for the period July 1, 1992 to March 31, 1993 and annual periods beginning April 1, 1993 [thereafter] through March 31, 1999, the maximum daily rate, excluding the allowable costs of transportation, for services provided to a registrant in a 24 hour period as described in Part 425 of this Title shall be 65 percent of the sponsoring facility's former skilled nursing facility rate in effect January 1, 1990 with the operating component trended forward to the rate year by the sponsoring facility's trend factor.

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Clinic Services for Federally Qualified Native American Health Centers not subject to licensure under Article 28 of the State Public Health Law

Reimbursement for federally qualified health centers located on Native American reservations and operated by Native American tribes or tribal organizations pursuant to applicable Federal Law and for which State licensure is not required will be established consistent with the methodology applicable to freestanding diagnostic and treatment centers, including federally qualified health centers which are licensed under Article 28 of the State Public Health Law. The reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Prospective all inclusive rates of payment will be calculated by the Department of Health, based on the lower of allowable average operating cost per visit or the group ceiling trended to the current year as permitted by law, except that rates of payment for the period ending September 30, 1995 shall continue in effect [thereafter] through September 30, 1999. The facilities will be compared with other facilities offering similar types of services. The rates will include a capital component which is not subject to ceiling limitations. Rates are subject to approval of the Division of the Budget. The facilities will be required to forward to the Department of Health on an annual basis any necessary financial and statistical information.

The provisions of this section pertaining to reimbursable base year administrative and general costs of a provider of services shall be deemed to be in full force and effect through March 31, 1999.

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